UnitedHealthcare Community Plan

**Prior Authorization Request Form**
**Fax Back To: (866) 940-7328**
**Phone: (800) 310-6826**

# Specialty Medication Prior Authorization Cover Sheet

**(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhccommunityplan.com for medication fax request forms.)**

## Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

## Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

## Medication Information

Medication: Quantity: ICD-10 Code:

Directions: Diagnosis: Refills:

**Physician Signature****: DAW (Initial here):

**Physician Signature****: By signing above the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication**.**

## Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐Yes ☐No

Is this medication a **New Start**? ☐Yes ☐No

If **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed**

## Delivery Instructions

**Note**: Delivery coordination requires a "**Physician Signature**" above and complete "**Provider Information**" and "**Patient Information**"

**Note**: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

**Ship to:** Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self Administered ☐ LTC ☐ Physician's Office ☐

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# Avonex / Rebif / Copaxone

## PRIOR AUTHORIZATION REQUEST FORM

**Complete *ENTIRE* form and Fax to: 866-940-7328**

| **Today's Date** | | |
|---|---|---|
| **SECTION A - PATIENT INFORMATION** | | |
| First Name: | Last Name: | Member ID: |
| Address: | | |
| City: | State: | Zip: |
| Phone: | DOB: | Allergies: |
| Primary Insurance: | Policy #: | Group #: |

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

| **SECTION B - PHYSICIAN INFORMATION** | | | | |
|---|---|---|---|---|
| First Name: | | Last Name: | | M.D./D.O. |
| Address: | | City: | State: | Zip: |
| Phone: | Fax: | NPI #: | Specialty: | |
| Office Contact Name / Fax Attention to: | | | | |

| **SECTION C - MEDICAL INFORMATION** | |
|---|---|
| Medication: | |
| Directions for use: | |
| Diagnosis (Please be specific & provide as much information as possible): | ICD-10 CODE: |

Does this patient have a diagnosis of relapsing forms of multiple sclerosis?
(Check response) □ YES □ NO

Did the patient have a first clinical episode with MRI features consistent with multiple sclerosis?
(Check response) □ YES □ NO

Additional Clinical Information:

_____

_____

_____

_____

Physician Signature: _____ Date: _____